BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

SOCIAL AND ENVIRONMENTAL FACTORS AFFECTING CHILDREN IN THE LATENCY PERIOD

A STUDY OF THIRTY CASES REFERRED TO THE BROCKTON CHILD GUIDANCE CLINIC

A Thesis

Submitted by

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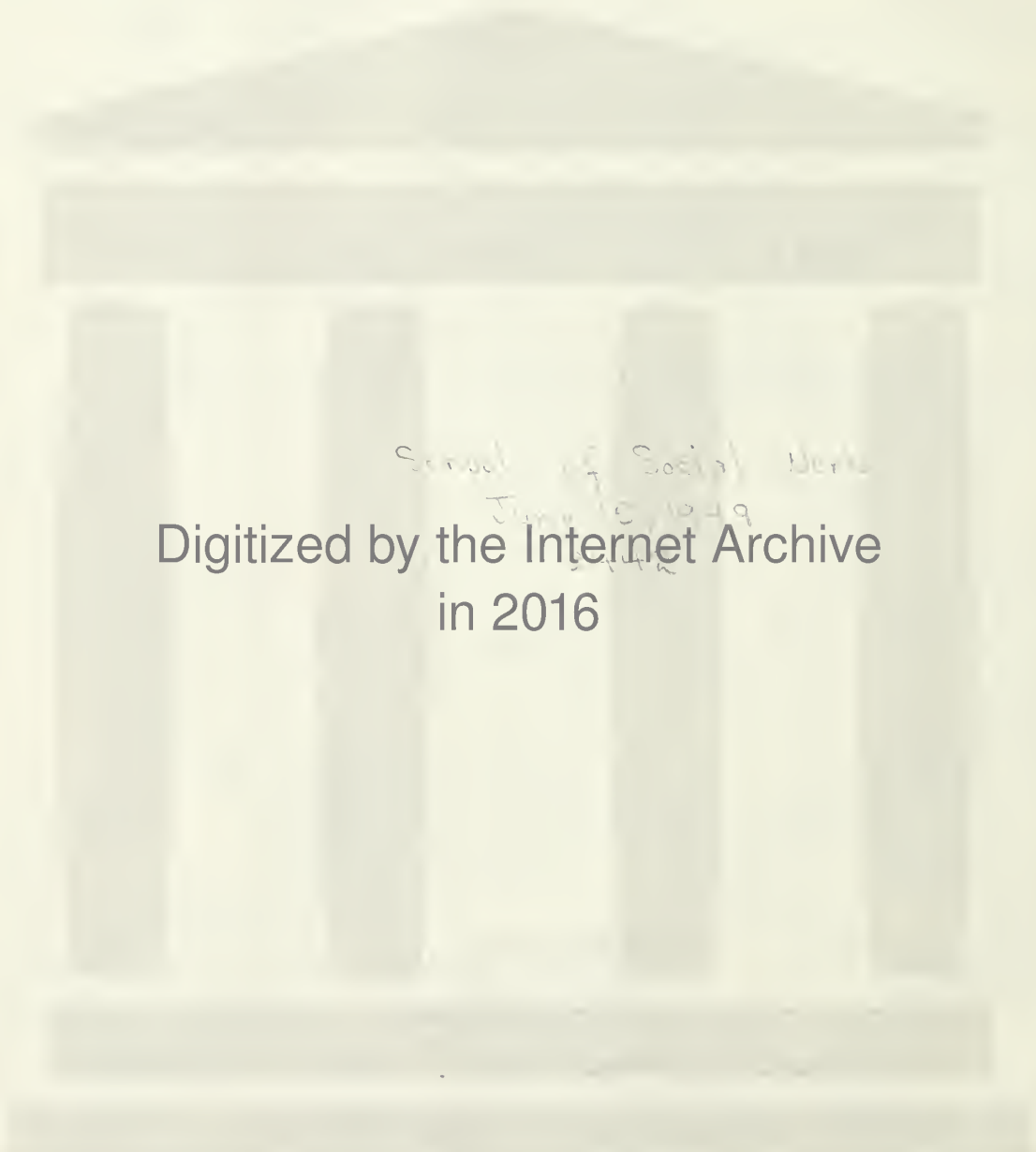

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CHAPTER I

INTRODUCTION

Purpose

The purpose of this thesis is to study the social and environmental factors and their influence upon the behavior of children referred to the Brockton Child Guidance Clinic during the latency period of their psychosexual development. The following questions will be asked:

1. What types of problems have been presented by these children and are they typical of what is to be expected during the latency period?
2. What social and environmental factors are found in their background?
3. What is the influence of these upon the children?
4. What was the clinical team able to do about these problems?

Scope and Method of Procedure

The thirty cases used for this thesis were closed cases of the Brockton Child Guidance Clinic of the Department of Mental Health, Division of Mental Hygiene of the Commonwealth of Massachusetts. Some of the cases were suggested

by the staff as those which had much recording. Others were selected by the writer on the basis of social histories being present. All cases fell within the age range of six through twelve when they were first seen at the clinic. If physical maturity was found to have occurred the case was discarded.

The cases came within the years 1940-1947. Thirty cases were selected as it was felt that this number would allow a sufficient variety of cases. Psychiatric diagnoses were available for all of the cases as well as social work evaluations. The writer has made use of these and in some instances has included her own interpretations also.

The writer planned to examine the cases by reading the case records of the psychiatrist, social worker, psychologist, and any other records which were in the case folders. A schedule was prepared for each case. Information was sought about the problems of each child, his family background, any traumatic experiences which may have occurred, his habits, his personality traits, his social adaptability, school adjustment, and his treatment at the clinic. For the most part the records were fairly complete, although in some instances pertinent information was lacking. In cases which were opened and reopened a child's age was considered at the first opening and the case was not used if the child were over twelve.

Nine cases were selected for presentation. They present a variety of problems. One shows an unusual home situation, another is a school problem, and still another is a problem from the class for gifted children. Three cases were chosen to show disorders of toilet training, one due to an organic cause and a case of enuresis and one of soiling which were due to emotional factors. Examples of anxiety, aggression, and masturbation are also included.

CHAPTER II

THE HISTORY AND ORGANIZATION OF THE MASSACHUSETTS DIVISION OF MENTAL HYGIENE

In 1922 the Division of Mental Hygiene was established by legislation in the Massachusetts Department of Mental Diseases. Dr. George M. Kline and Dr. Douglas A. Thom, as well as other psychiatrists, had shown the Legislature the need of a preventive program. This resulted in the creation of the Division of Mental Hygiene with Dr. Thom as Director. The responsibility of the Division was described as that of "all matters affecting the mental health of citizens of the Commonwealth, and investigation of causes and conditions that tend to jeopardize mental health."[1]

Prior to this the mental hygiene movement had rapidly grown, mental hospitals had employed social service, traveling school clinics were established for retarded children, and the Division for Examination of Prisoners was established in Massachusetts.

In 1922 the National Committee for Mental Hygiene, through its Division for the Prevention of Delinquency, set up a series of demonstration clinics. These were planned for five years, were financed by the Commonwealth

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[1] Edgar C. Yerbury and Nancy Newell, The Development of the State Child Guidance Clinics in Massachusetts, p. 4.

Fund and were established in eight Massachusetts cities.

In 1923 the Division of Mental Hygiene established three clinics in Boston, and in 1924 four more were opened. Assistance in starting clinics in new cities was given by the Massachusetts Society for Mental Hygiene. Lectures, conferences, and publicity work were promoted. The original idea was to establish the clinics and then transfer them to the auspices of a private organization or hospital or a state hospital. This has been followed except for a few instances.

In 1933, the tenth anniversary of the State Child Guidance Clinics, there were six demonstration clinics which had been transferred to the management of state hospitals, there were clinics established by ten hospitals themselves in eight communities, and there were nine clinics being directed by the Division.

From 1933 to the present time the period has been characterized as a time of stabilization--although some new state hospital clinics were established as well as the Brockton clinic.[2]

The clinics under the direct leadership of the Division at the present time are as follows:

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[2] Ibid., p. 11

1. West End (Boston), established in 1924
2. Quincy, established in 1926
3. Lowell, established in 1925, closed in 1928 and reopened in 1932
4. Brockton, established in 1938

Children of normal intelligence up to fourteen years of age are admitted to the clinics.

The Brockton Child Guidance Clinic

On September 30, 1938, the Brockton Child Guidance Clinic was established for one-half day a week. In 1939 it was open one full day a week, and in 1945 the clinic time was increased to two full days a week. At the present time it is open two full days a week. The Brockton Clinic is partially sponsored by the School Department and the offices are located in the high school. The Educational Consultant of the School Department works in close cooperation with the clinic staff, both in the selection and treatment of the school cases.

The clinic staff consists of a psychiatrist who heads the team, two psychologists, two full-time trained social workers, and two second-year social work students from the Division of Mental Hygiene. A full-time speech therapist, two remedial reading tutors, and a secretary-receptionist, who manages the clinic, are paid by the Brockton School Department.

Cases are referred by the school, the families of the children, by friends, by other agencies and hospitals. The clinic serves some of the surrounding towns as well as Brockton proper.

When a child is referred to the Brockton Child Guidance Clinic, the usual procedure is for the mother and child to come to the clinic together. The child is studied by the psychologist, who gives him intelligence tests. In this way if a child is found to be mentally deficient he is not accepted for treatment, but is referred to another agency. The social worker interviews the mother while the child is with the psychologist. At this time she obtains the intake information. In some instances a social history is obtained at this time. In other instances it may be obtained later. The psychiatrist sees the child after the psychologist has completed her study. At this time the psychologist has given the psychiatrist the results of her study and the social worker has also given her the intake information. The psychiatrist sees the mother during her first clinic visit. She obtains the developmental and medical history and formulates a diagnostic impression and a tentative treatment plan.

During the weekly conference which the psychiatrist has with the social worker the psychiatrist discusses the case and decides what the future plan of treatment shall be. The usual plan is for the social worker to see the mother and the school, and the psychiatrist to see the child.

Besides the treatment of the child and casework or psychotherapy with the parent, the clinic renders diagnostic and consultative services. It also studies and tests the candidates for the class for gifted children. The classes consist of grades four, five, and six, a new fourth grade being formed each year. The clinic staff is very much interested in these children and carefully follows their progress.

The class for gifted children was formed with the purpose of stimulating the well-adjusted child of superior intellectual ability as well as assisting the child of superior intelligence who has social and emotional problems.[3] It is felt that children of superior ability are sometimes not sufficiently motivated in the ordinary classroom and may not work up to their ability or may become behavior problems as a result.

The teachers of the appropriate grades are requested to send lists of children whom they regard as possible candidates for the class. In addition to this, the Brockton Child Guidance Clinic keeps a list of children whom they believe may be eligible for this class. Any parent may request that his child be studied for the class.

In making a referral for this class a teacher usually

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[3] Edith Fox Carlson, Project for Gifted Children: A Psychological Evaluation, p. 648.

considers one of the following criteria:

1. If the child has made a high score on intelligence tests given in the school.

2. If a child has shown unusually high achievement in school.

3. Those who are not in the previous two categories but who appear to have good ability.

After a child is suggested as a possible candidate for the gifted class the clinic makes the study which consists of psychological tests--including the Terman revision of the Binet. A score of one hundred thirty on this is usually considered as the minimum score acceptable. In addition to a qualitative analysis of the psychological tests which are given, a social history is obtained so that the emotional and social factors can also be evaluated.

The size of the class for gifted children is limited. The original class consisted of seventeen pupils. At the present time there are eighteen pupils in the class, eight of whom are in the fourth grade, five in the fifth, and five in the sixth. All of the children have social studies together and also work together on various projects and clubs. Arithmetic and languages are taught to each grade separately, however.

The class for gifted children is located in the Ellis Brett School, which also houses some regular school classes so that the children have the opportunity to associate with children who are not in the gifted class.

A social worker visits the class at least once a month and confers with the teacher about the progress of each child, obtains any marks which have been given, and assists the teacher with any problems which may have arisen to prevent the child's best adjustment to the class.

CHAPTER III

GENERAL CHARACTERISTICS

The Latency Period

There is some diversity of opinion in regard to the age range of this period. Latency is described in the psychiatric dictionary as follows:

> The definition of the latency period is used principally in psychoanalysis and refers to the psychic period in one's life extending from the end of the infantile to the beginning of the adolescent stage. In point of years it normally begins at five and terminates at about the age of puberty. It is normally a relinquishment of sexual expressions characteristic of the infantile phase in favor of activities and interests that take on the qualities of sublimation and reaction formations. For example, in the latency period, cleanliness takes the place of dirtiness, display of knowledge replaces display of body; interest in sex is transformed into prudery.[1]

English and Pearson state that the latency period is between the ages of six and ten, or from six to the onset of puberty. The writer established the limits of six through twelve years providing physical puberty had not arrived, as she felt that most of the group would be of the male sex and that physical puberty would not have been reached at twelve years.

The latency period is sometimes called a quiet period in a child's life, but this is not completely quiet. It is

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[1] Leland E. Hinsie and Jacob Shatsky, Psychiatric Dictionary, p. 315.

more calm than the earlier stages of a child's development and less stormy than his adolescence.

Social Adaptability

English and Pearson tell of the tendency of the latent children to want friends of the same sex and to form gangs. They write:

> They advance their own theories among themselves of life, birth, death, adventure, etc., and relate to these topics what they learn about the world in general. Many false theories and much misinformation concerning physiology is present--particularly in relation to the question of sex. The gangs and groups fight each other, either in a supervised way on the sand lot or in football games or under the auspices of the school athletic plan, and thus work off much hostility and aggression. This particularly is true of boys.[2]

The authors feel that the children form gangs as a protest against the parents for not having told them the truth about sexual matters and for not showing as much interest in them as they should. They act toward the parents in the same manner in which the parents acted toward them and have secrets which they don't tell the parents. More shared interests with a child as well as more truthfulness could help remedy this situation.

Aggression

English and Pearson describe the tendency of the children

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[2] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, p. 134.

of latency years to be cruel and aggressive, and tell how they want to control or feel they can control someone. They write that these children are less supervised by older people than they were in the earlier stages of their life and form groups, hurting those they dislike by excluding them from the groups. They verbalize their scorn of those they dislike, who may include either children or adults. The authors feel that an explanation of the cause of the cruelty and dislike of the children is the treatment which they have received from their parents. The children have not had the advantage of especially considerate treatment or kindness from adults in the past and are resentful of this.[3]

Sex Antagonism and Indifference

English and Pearson tell of the disinterest and lack of friendliness which boys and girls of the latency years display toward each other. The authors feel that the cause of this is the numerous problems which the children have during the oral, anal, and genital stages of their psychosexual development which the adults do not attend to sufficiently. As a result of this they reach the next stage of their development, the latency period, with much hostility and leftover aggression against their parents, who represent authority to them. They write:

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[3] Ibid., pp. 137-138.

> Having been on poor terms with their parents, they cannot show more consideration for their contemporaries than has been shown them. They have been hurt, neglected and ignored, and they get satisfaction out of doing the same thing to others. In the solution of the Oedipus complex parents are not always wise enough in the manner in which they relate themselves to their children. Often fathers do not make as good friends of their daughters as they should. So girls and boys suffer a disappointment at the hands of the parents, not having learned enough of friendship to pass it along to each other. Each sex seems to have its own language. They become segregated. They seem to need someone and something to hate so they look down disdainfully upon the opposite sex.[4]

The authors suggest that the parent, especially the father, take an interest in his child even though he is at school the greater part of the day.

School

It is during the latency period a child's life that he enters school. He has to learn to adjust to other children and he has rules and regulations which he need obey. He has a teacher, who exerts a great influence upon him, not only in regard to his personality development. Although the teacher acts as an authority for the child after his departure from home, the child has moments when he has to be his own authority. The development of his superego or conscience occurs during latency. Many of the child's beliefs are taken directly from the parents, but he also is influenced by the school situation. This could include not only the influence

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[4] Ibid., pp. 134-135

of the teacher, but also the influence of knowledge upon the child. He reads about people whom he wishes to be like.[5]

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[5] Ibid., p. 139

SOME GENERAL CHARACTERISTICS OF THE THIRTY CASES STUDIED

TABLE I

AGE AND SEX DISTRIBUTION

Age	Number males	Number females	Total
6	5		5
7	4	1	5
8	5	2	7
9	6		6
10	2	1	3
11	3		3
12	1		1
Total	26	4	30

Twenty-six of the cases studied, or 85 per cent, are male, and four cases, or 15 per cent, are female. Although more boys than girls do attend clinic, the difference is not necessarily this great. In the year 1947, for example, there was a total of one hundred sixty-one cases referred to the clinic. One hundred nineteen of these, or 65 per cent, were boys, and forty-two, or 35 per cent, were girls. Seventy-four per cent of the children were between the ages of six through twelve. The mode in 1947 as well as in the group studied by the writer was eight years and the next largest scatter was at nine years. The writer feels that one reason for the cluster around the younger years is the fact that the clinic is closely coordinated with the School Department. The school personnel is aware of the function of the clinic

and for the most part are alert to the difficulties which the child might present in his first years of school.

TABLE II

SOURCES OF REFERRAL

Referring agency	Number referred
School	19
Parent	4
Other agency	3
Hospital	4
Total	30

The largest number of referrals are from the school, which can be explained partially by the clinic's presence in the School Department and the activity of the educational consultant, who constantly visits the schools and refers children to the clinic.

TABLE III

INITIAL PROBLEMS AS REFERRED TO THE CLINIC

Problem	Number
Possible candidates for gifted class	6
Poor school adjustment	13
Speech difficulty	1
Enuresis	2
Soiling	2
Masturbation	1
Imaginative stories	1
Behavior	2
Nervousness	1
Anxiety	1
Total	30

It is interesting to note that upon further investigation there is a multiplicity of problems presented by each child.

TABLE IV

HABIT DISORDERS OF GROUP STUDIED

Habit	Number of Children
Eating	11
Sleeping	12
Masturbation	7
Enuresis	11
Soiling	4
Thumbsucking	3
Nailbiting	5
Total	53

Thirty-seven per cent of the group studied were found to be capricious eaters, 37 per cent suffered from enuresis, and 40 per cent had sleeping difficulties.

In Table III poor school adjustment, which was the most frequent problem, is an ambiguous term and may include learning difficulties as well as social difficulties. This type of problem is typical of the latency years as this is when the child is presented with the need to associate successfully with many other children his own age as well as to adjust to a learning situation. Imaginative stories are not unusual in the latency period. Behavior problems may be a common occurrence also. Soiling, enuresis, thumbsucking, nailbiting, masturbation, and speech disorders all represent emotional deviation. The degree of nervousness and anxiety would determine whether or not they were characteristic of this period. If they were excessive they would not be typical of the period.

In Table IV disorders of eating, if they consist of refusal to eat certain foods, are not uncommon to any stage of a child's life. Extreme eating difficulties are not common to this period. Extreme sleep disorders are not characteristic of the latency period, whereas minor ones may not be unusual in any period of a child's development.

FAMILY BACKGROUND

The influence of the family, which gives the child his heredity as well as his first contacts with the outside world, is indisputable. Flugel, in writing of the influence of the psychological atmosphere of the home life upon human character and development, states:

> It would seem that, in adapting his attitude toward the members of his family circle, a child is at the same time determining to a large extent some of the principal aspects of his relations to his fellow men in general; and that an individual's outlook and point of view in dealing with many of the most important questions of human existence can be expressed in terms of the position he has taken up with regard to the problem and difficulties arising within the relatively narrow world of the family.[6]

The child in the latency period has just experienced the turmoil of attempting to solve his Oedipus conflict. He may carry attitudes resulting from this problem throughout his life. Flugel, in writing of this, says:

> Certain of the secondary hatreds consequent upon incestuous love are in many individuals incapable of being completely and satisfactorily resolved in any of the normal ways, but become instead displaced on to parent substitutes in the same way as the love impulses which they accompany. The same fate of displacement awaits in most cases, those more direct and primary hatreds which are consequent upon the parents interference with the child's more general wishes and desires. In the course of the individual's life the authority over his expressions, activities and general mode of living originally exercised by the parents, passes in succession, wholly

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[6] J. C. Flugel, The Psychoanalytic Study of the Family, p. 4.

> or partly to a number of other persons; to whom the feelings directed to the parents in virtue of the exercise of their authority is then transferred.[7]

One might expect that a good proportion of the children referred to a child guidance clinic would have defects in their familial backgrounds. The most obvious defect is the home which has been broken by death, divorce, desertion, or illness. In describing the marital status of the parents of the thirty children studied a normal home was described as that in which both parents are present, the step-parent homes contained one step-parent and one real parent, and each compound household contained a father and one child who had moved in with another complete family.

TABLE V

MARITAL STATUS OF PARENTS OF GROUP

Type of home	Number
Normal	26
Step-parent	2
Compound	2
Total	30

Twenty-six of the thirty children came from normal homes. This is different from what one would expect, for one often reads of the effects of broken homes upon the personality development of children. This naturally leads us to assume that children from a home containing two parents would have

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[7] Ibid., pp. 117-119

few serious problems. The writer found that although two parents were present in twenty-six of the thirty homes, there were a multitude of problems presented in these homes. One or both parents may markedly reject a child, or a child may be overprotected with the result that he is overdependent and may not be able to associate successfully with other children. An extremely poor relationship between the parents also shows its results in the child's behavior. Thus one can see that the difficulties of the twenty-six children studied are not results of broken homes, but may arise from conditions within these homes.

Occupations of fathers of children in the group studied

It was impossible to determine the economic status of all thirty families studied. In some instances home visits were not made, in other instances the subjectivity of the writer would be involved as the information was not available in the records. A possible criterion is the vocational classification of the fathers. In no instance was a mother found to have full-time employment outside the home.

TABLE VI

OCCUPATIONS OF FATHERS OF CHILDREN REFERRED

Occupation	Number
Business men	4
Professional men	3
White collar men	4
Skilled and semi-skilled laborers	16
On old age assistance	1
Unemployed	2
Total	30

The largest number of fathers were employed as skilled and semi-skilled laborers, which is characteristic of Brockton's total population. Only three are unemployed--one receiving old age assistance. It would appear as if the economic status of the majority of families ranges from poor to average.

TABLE VII

NUMBER OF SIBLINGS IN FAMILY
INCLUDING PATIENT

Number	Frequency
One	5
Two	12
Three	4
Four	0
Five	4
Six	3
Seven	0
Eight	1
Nine	1

The mode is the family containing two children. An example of a case which tems from a broken home can be seen in the illustration of C. Z.

The School Situation

During the latency period the child is undergoing the transition from home to school. For some children this cleavage is especially difficult. The child may identify the teacher with the mother and react to her in a similar way. He may have difficulty in acquiring knowledge, for his earlier curiosity in regard to sexual matters may have been suppressed and he may believe that all knowledge is bad. The child in the latency period has gone through the process of solving his Oedipus conflict. He may have considerable hostility and much residue aggression against authority (parents). Because of the poor relationship between the child and his parents he may react to others in authority in a like manner. If the parent of the opposite sex is not an understanding person, the child may transfer this feeling to all other members of the same sex.

Anna Freud tells of the use which education makes of

the latency period, for the child is more capable of learning and is less subjected to his instincts. She tells how he finds that he is just one of many and how he has learned something of social adaptation. She writes:

> Instead of continually seeking to gratify his desires, as formerly, he is now prepared to do what is required of him and to confine his pleasures to the times allowed for them. His interest in seeing everything and finding out the intimate mysteries of this environment has now been transformed into a thirst for knowledge and love for learning.[8]

In the Little Red School House, an experimental school in New York, a group of ten seven-year-old children who ranged from average to very superior intellectual ability and were from different types of homes were observed in school in order to see what is characteristic of this age group. The authors write that:

> There is reason to believe that this is the time in a child's life when he is not only gathering and organizing information but when he is also developing his basic attitudes to the important problem of understanding and inquiring: when it is most possible for his interests to become a primary part of himself and thereby gain strength and potency. If we can discover felicitous educational conditions for this period of development, we may be on the road to mitigating one of the serious social disadvantages of our times, namely the relative indifference of individuals to events and circumstances which they do not recognize as affecting their lives immediately, and the affective dissociation between what they may know to be true and what they feel impelled by the force of emotional identification to do something about.[9]

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[8] Anna Freud, Psychoanalysis for Teachers and Parents, pp. 62-89.

[9] Barbara Biber, Lois B. Murphy, Louise P. Woodcock, Irma S. Block, Child Life in School, p. 13.

In the Little Red School House study it was found that although the atmosphere was a noncompetitive one the stress and strain was only partly relieved. They might not have been competitive with each other, but they showed how they were holding themselves to standards of their own with psychological effects resembling what happens when children are held to standards set by others. This was shown by self-criticism and alibis. They found that the child's clearest conflicts seemed to deal with accomplishments, ability, performance, standards set by themselves; being accepted as a member of the child group; establishing a relation with adults and the authority they represent. It was seen that the children project their hostility and aggression and objectify many of their feelings.

An example of difficulty in adjusting to the school situation is seen in the case of J. L.

Intelligence Quotients of Thirty Children Studied

The fact that the emotional condition of a child may affect the results of an intelligence test is generally accepted. In a few instances the psychologist has made notations on the test that she believes that the child has better ability than the test indicated. With this in mind we can see that one of the children is classified as borderline, eight as dull normal, eleven as average, three as bright normal, and seven as very superior. Six of the very

superior were referred as possible candidates for the class for gifted children and were accepted for this.

In the normal curve of the distribution of intelligence scores among the general population one would expect to find the largest proportion in the average range (90-110), a few in the low groupings, and a few in the high groupings. There is a larger scatter at the upper limit because six of the children had exceptional intelligence and were referred as candidates for the class for gifted children. Those children classified as dull normal might possibly be in the average group were it not for their emotional disturbance.

TABLE VIII

CLASSIFICATION OF THE GROUP ACCORDING TO INTELLIGENCE QUOTIENTS ON THE BINET TEST

Intelligence quotient ratings	Frequency
70-79	1
80-89	8
90-99	7
100-109	4
110-119	3
120-129	0
130-139	3
140-149	1
150-159	3
Total	30

In the group of thirty cases studied it was seen that one of the third grade children was referred as a possible candidate for the gifted class as were five of the fourth grade children.

TABLE IX

GRADE PLACEMENT OF CHILDREN IN GROUP

Grade	Frequency
Pre-school	1
Retarded first	1
First	4
Second	6
Third	5
Fourth	10
Fifth	2
Sixth	0
Seventh	1
Total	30

Excluding the candidates for the gifted class, the majority of the children in the group studied were in the first four grades of school and the number in each grade was fairly equal.

The Gifted Group

The formation of the class for gifted children in 1940 had the following objectives.

> It was an experiment to determine whether a class set up for gifted children in the middle years of childhood could serve a mental hygiene function; whether it could be used as a therapeutic device for children with emotional problems, and as a preventive measure in helping intellectually superior boys and girls avoid those pitfalls in personality development which are often encountered by the highly endowed.
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> It is different from other classes for the gifted because of the emphasis on preventive and therapeutic aspects. The aim was to organize a class that would be of value not only to the well-adjusted youngster of superior abilities, but also to the highly endowed child with social and emotional problems. The function in addition to the therapeutic goal, should be in other projects for the gifted, to help each child develop into a well-adjusted happy individual with his

> intellectual faculties trained and utilized to a maximum, to bring out leadership qualities, to serve as a stimulus to creative activity and to indicate a way of meeting the need of democracy for people of distinguished abilities.[10]

Of the thirty cases studied four boys and two girls were referred for study as possible candidates for the gifted class and all six were accepted. A social worker visits the class at least once a month and in some instances works with the parents as well. A social worker visits the class at least once every month to discuss the progress of the children, to obtain the marks of the children and to discuss any social or emotional problems which the child displays and which may affect his satisfactory adjustment to the home or school.

An example of a problem of a member of the class for gifted children can be seen in the case of M. H.

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[10] Edith Fox Carlson, Project for Gifted Children: a Psychological Evaluation, p. 648.

CHAPTER IV

CLASSIFICATION OF PROBLEMS:

THE CHILD PRESENTING DIFFICULTIES IN TOILET TRAINING

Enuresis

Enuresis is not unusual during the latency years. According to some psychiatrists it may be present from the third year until puberty, when it usually stops. English and Pearson cite five psychological concepts which they feel may be responsible for this--after the organic factors are ruled out. They are listed as follows:

> The desire for attention, the desire for love and physical gratification, the hostility and revenge against the parent who does not give the desired gratification, and also against the other parent who may be held responsible for the thwarting, the memory of the real or phantasied danger by which the revenge is gratified, and the need for punishment for such horrible and reprehensible desires--find expression in the enuresis, and the child, suppressing them all into the one symptom, can continue to live blandly unconscious of the presence of his real feelings.[1]

Eleven of the children studied, or 37 per cent, presented disorders of bladder control. In one case there was an organic basis. In other cases it was felt to be a psychological problem. In no instance was it the only problem found. An example of a boy who was referred to the clinic for another problem, but who was also suffering from enuresis can be seen in the case of G. R.

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[1] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 128.

Soiling

By the time the child reaches the latency years he ordinarily has been trained for bowel control for several years. When the child is unable to control his bowels several possibilities must be considered. First it is necessary to consider the possibility of organic injury. It may be that through no fault of his the child lacks the control of the bowel muscles. Another possibility is regression due to many different causes--such as jealousy, lack of love, and other psychological factors which English and Pearson mentioned in connection with enuresis. Soiling can also be a form of aggression directed against the parents, as they also mention. Whatever the cause of the soiling, the effect of this upon the child, the parents and the other people in the environment should be considered.

In the group of thirty cases studied it was found that four children soiled frequently. There were other problems related to this also.

The Anxious Child

Almost all children have fears at one time during their lives. Most of these are transitory, however. When it is found that specific fears persist and may handicap a child in making an adequate adjustment, an investigation is deemed necessary. English and Pearson found anxiety was not an uncommon occurrence in the child of latency years. They

describe it as:

> . . . the result of an individual's inability to gratify his instinctual desires. These desires if ungratified and not admitted to consciousness, manifest themselves first as anxiety; i.e., the individual behaves and feels as if he were in the presence of danger, and his clinical symptoms both physical and mental are those of fear.[2]

They further state:

> An acute anxiety attack is a sign to a child's ego that he has a wish within his mind which if expressed will result in one of the three major fears of childhood which are desertion by his parents, loss of parental love or bodily injury, mutilation or death.[3]

In the group of thirty children studied the writer found that twelve of the children showed evidence of fears. In some instances these fears were almost continually present so that the child was in a state of near anxiety.

TABLE X

TYPES OF FEARS PRESENTED

Type of fear	Incidence
1. Bodily injury, mutilation or death	8
2. Desertion by parents	2
3. Loss of parental love	1
4. Other	1
Total	12

In Table X one can see the incidence of the specific fears mentioned by English and Pearson. Some of the other Fears noted did not fall specifically within these categories. Fear of bodily injury, mutilation or death, with eight examples listed, was the most frequent fear. A possible

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[2] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, pp. 68-70.

[3] Ibid.

explanation of this may be that many of these children have just experienced the Oedipus conflict and some have still not solved it adequately so that the castration conflict may still be present. The case of S. T., which is discussed in the case presentations, is an example of a boy who is afraid of death. He has known of numerous deaths and has been told that people die in their sleep so he is afraid that he will die in his sleep and he also fears the dark. His father is a brutal man with whom it is hard for him to identify and his mother shows undue interest in his penis so that it is difficult for him to resolve his Oedipus conflict. His parents also have fears.

One boy, aged eight, worried about his appearance and was over modest. He once told his mother he wished he were a girl. Upon investigation it was found that he had seen intercourse among the farm animals, had seen his mother pregnant, and had experienced sexual relations with his four-year-old sister with whom he shares a room.

A twelve-year-old boy was afraid that his mother would become ill and die. It was found that he once masturbated and had bad dreams. His mother has been overprotective, has refused to answer his questions about sex, and has been the more strict disciplinarian of the two parents.

Another boy, aged eleven, was extremely worried about his father's going to war. Although this was a possibility it was a remote one. He is an only child who is closer to

his over-protective mother than to his father. Until he was seven years old he did not play with other children because his mother was afraid that his hernia would be affected.

Anxiety can manifest itself in sleep disturbances. Table IV showed that twelve of the children studied presented sleeping difficulties. These included two who sleepwalked, three who talked in their sleep, two with insomnia, and five who had night terrors. Eight of the children showing evidence of sleeping difficulties also presented fear problems. English and Pearson write that the child who has insomnia may fear what he may do in his sleep. This may include such things as enuresis or soiling. They also suggest that he may suffer from unrelieved instinctual tension which is usually sexual.

They classify sleepwalking, talking and night terrors together. Night terrors they describe as a distorted memory of an actual event which usually deals with a mutilation threat because the child was seen masturbating at some time. Because the child was threatened that his genitals or his hands would be cut off he stops his masturbation, but he still has the wish to masturbate. He feels that he cannot even think of masturbation.[4]

An example of fear in a child of latency years which shows the influence of the social and environmental factors

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[4] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, pp. 72-76.

upon his behavior can be seen in the case of S. T.

Disorders of the Oral Function

English and Pearson found that some children experienced disturbances of the functioning of the mouth and the upper part of the gastrointestinal tract during the latency years due to anxiety, or the anxiety was removed by conversion of the conflict into a disturbance of these functions.[5]

Anorexia

Although twelve of the thirty children studied by the writer displayed some food capriciousness by refusing to eat certain foods, there was no evidence of severe anorexia or nausea.

Fingersucking

In the normal course of development a child should have passed through the stage of thumb or finger-sucking by the time he reaches the latency period. The present thought on this subject is that this is a symptom of a lack or fear which the child is experiencing. English and Pearson suggest that:

> When a child continues his fingersucking beyond the age of four or five it is helpful to investigate the home situation carefully to ascertain if there are adverse parental attitudes that are making the child too

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[5] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, p. 172.

> miserable and unhappy to permit him to give up his infantile forms of gratification.[6]

Another type of fingersucking described by them is when a child has stopped his fingersucking and then regresses to the oral stage and sucks once more. In this instance they say that the fingersucking is due to "an insoluble difficulty which the child has met in his development." Possible insoluble difficulties suggested by them are insecurity due either to the birth of a sibling, fear of lack of his mother's love, or castration threats because of the child's desire to masturbate.[7]

Three of the children studied were known to suck their thumbs. The case of M. N. presents a multitude of problems. He is rejected by his mother and he reacts to this with hostility and aggression. He throws rocks, breaks windows, truants, lies, and hurts the cat. The birth of a new baby has been a traumatic experience for him. Another child who sucks his thumb is B. C. who was referred to the clinic because of his truanting. B. has experienced a lack throughout his life for his mother has greatly rejected him. He is the oldest of five children. Although the mother rejects all of the children she especially rejects B., who was born when she was eighteen years old. This may be the insoluble difficulty which prevents B. from giving up his thumbsucking--from which

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[6] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, pp. 194-195.

[7] Ibid.

he receives some gratification.

Nailbiting

Nailbiting is a very common occurrence in the latency period as well as in other periods of a child's life. Severe nailbiting can be regarded as a neurotic symptom. English and Pearson write:

> Severe cases of nailbiting are motivated in part by the desire of the child to annoy and humiliate the parents--and the parents' reaction indicates clearly that the child does accomplish this desire. At the same time the fact that the parents do get angry and that after the child bites his nails deeply that the biting itself is painful, and the fingers afterward, indicates that there is another motive, i.e., the need to punish himself for his resentment. Severe nailbiting therefore has the structure of a neurotic symptom. Essentially it is an aggressive hostile act directed against one's own person because one is afraid to direct it against the real object. In most cases the real object is the parents, frequently the mother.[8]

They described one child who was resentful because of maternal over-protection which resulted in her feeling helpless in a new situation. The child felt ambivalent as she wanted her mother's attention and her hands crept to her mouth as a symbol of this. She also felt resentment and bit the fingers which resembled her mother. They also mention the case of a child who was threatened with punishment because of masturbation. The child was angry because he had to cease his activity, he wished to regress to fingersucking, but bites his nails because of his hostility.

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[8] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, pp. 196-197.

Five of the thirty children studied by the writer bit their nails. In all five instances their relationship to their mothers did not appear to be a warm one.

The Aggressive Child

The close relationship between frustration, anxiety, and aggression is a familiar concept. Hyman Lippman has written of the hostile aggression which develops when anxiety from repressed conflict is felt in consciousness. He found that this aggression could be directed against the play material, the furniture, or the analyst in the therapeutic situation, or the parent in the home. He also found that the anxious child was usually aggressive and the destructive child suffered from anxieties.[9] Gordon Hamilton in writing of the outwardly aggressive child or the child who has the primary behavior disorder states:

> The child with the primary behavior disorder fears attack from without; whereas the anxious, psychoneurotic child feels that his danger comes from within; that is from his own primitive desires. The former has a deficient super-ego; the latter a too severe super-ego.[10]

She further writes:

> The child who acts out his impulses has experienced so little love that he has never learned it is worth while to sacrifice for it. The anxious child has always experienced some love, but never enough and never good enough, not consistent, but rigid, or dutiful, or intermittent.[11]

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[9] Hyman Lippman, The Treatment of Aggression, p. 415.
[10] Gordon Hamilton, Psychotherapy in Child Guidance, p. 25.
[11] Ibid.

English and Pearson write of three groups of situations which can cause an aggressive reaction. They are as follows:

> 1. The child is in real danger and attempts to free himself by attacking and destroying the object or person whom he fears--i.e., by being angry with it.
>
> 2. The child is deprived of some desired pleasure and his anger is directed at the object or person which has deprived him.
>
> 3. The child is being tempted to do something which is both a desired pleasure and a forbidden one. The child feels the temptation is dangerous and his anger is directed both at the tempter who is inducing him to do something that will have unpleasant consequences and at the prohibitor who will not let him do it.[12]

They sum this up by saying that the chronic aggressive state results when a child is exposed to some persistent danger, deprivation or temptation.[13] Lack of love is the most common deprivation.

The child in the latency period is undergoing the experience of attempting to control his instincts and of managing his aggression. Aggression can be managed by turning it outward in anger but it is somewhat appeased when there is an adequate amount of love. It also can be sublimated by directing it toward school work. When this does not happen, it can manifest itself in a chronic aggressive state when a child is over-anxious to fight and be destructive.

In some instances aggression may be turned inward and then the child has neurotic symptoms. English and Pearson

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[12] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 141.

[13] Ibid.

describe this as occurring when the child finds his aggressive feelings turned toward a person he loves. As a result of this he feels guilty and releases the aggression upon himself. This can be sublimated, but may result in masochistic tendencies or other neurotic or psychotic manifestations.[14]

The thirty cases studied by the writer included children who were overtly aggressive. The following table shows the instances where this was an outstanding problem.

TABLE XI

INCIDENCE OF AGGRESSION IN GROUP STUDIED

Type of Aggression	Number
Cruelty	2
Truancy	5
Stealing	5
Destruction of Property	5
Excessive Hitting and Fighting	9
Total	26

It should be remembered that many of the other children had aggressive tendencies--which may have been normal reactions under the circumstances, but these were the seventeen extreme cases. Twelve of the children manifested their aggression in more than one way, and five showed it only by excessive hitting and fighting. The case of M. N. shows how one of the children studied expressed his aggression and the influence which the social and environmental factors had in the causation of this.

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[14] Ibid., pp. 150-155.

Interest in Sex

The latency period is often characterized as a period when the child's sexual interest is at low ebb. Sex desire is supposedly suppressed and its energy used to acquire knowledge. As all of the sexual energy is not sublimated, some of it is found in the interest of latency children in others of the same sex and age.[15] Thus it is that gangs of children--usually of one sex--play together.

Masturbation

The latency period is not a time when much masturbation ordinarily occurs among children. When it does occur it is wise to examine the family relationships for a possible cause. Lack of love may be one cause of masturbation. The child has no one to love him so he turns to himself for his pleasure. English and Pearson cite the overfussiness and over-restrictiveness of some parents as another cause. It may be that a child has to cease almost all activity for fear he will receive adverse parental criticism with the result that he obtains his only pleasure through handling himself.[16]

Homosexuality

Lack of interest in the opposite sex is a characteristic of the latency period. English and Pearson describe the

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[15] Ibid., p. 44.

[16] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, p. 222.

disdain and rejection which the latent child has for the opposite sex saying that the boy has this because of his loathing and fear of the female genitals and the girl because she attempts to deny her strong aggressive desires and extreme interest in and envy of the penis. They further describe the boy and girl gangs in which sexual matters are discussed and actual sex play may take place.[17]

Sexual Curiosity

Augusta Alpert in the children which she studied for a period over ten years found that the six-year-olds exhibited much curiosity in regard to sexual matters. They are conscious of the difference between sexes and want to know why this is. She writes that if the adult does not supply this explanation they will find out for themselves. The purpose is not a purely intellectual one for it has a strong emotional drive. She found that if their curiosity has been adequately handled the mutual exploration among six-year-olds diminishes and disappears.[18]

Cruelty

In writing of cruelty English and Pearson say:

> All small children are cruel to a lesser or greater degree. This cruelty is a combination of the desire to master and control and of curiosity, so is really

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[17] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 173.

[18] Augusta Alpert, The Latency Period, p. 126.

> an activity from which the child gets pleasure. . . . With the onset of the latency period, the cruelty becomes gradually replaced by sympathy for others and kindness.[19]

They suggest the advantages of letting the cruelty find expression in sports such as wrestling, boxing, etc.

The writer found that most of the thirty children studied were more interested in playmates of their own sex than those of the opposite sex. Most of them also played in large groups, if this was at all possible. In some instances an aggressive or disagreeable child was not completely accepted.

Of the thirty children in the group, seven boys were known to have engaged in sex play at one time or another. Four of these were with other boys and three with both boys and girls. When there is sex play between the opposite sexes it is usually considered to be of an exploratory nature in the latency years.

One child showed an undue curiosity about sex, asking an unusual number of questions and seven of the thirty children were known to masturbate. One of these is described in the case of W. B.

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[19] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 171.

CHAPTER V

CASE PRESENTATIONS

In this chapter nine cases are presented. Although more than one problem is often presented in a case and there may be considerable overlapping of problems the writer selected these cases as examples of different groups.

The case of C. Z. is an example of an unusual home situation, one of the four homes which did not include two natural parents.

The case of J. L. is the problem of a girl who refused to attend school.

The case of M. H. is an example of a boy who presented problems and who is in the class for gifted children.

G. R. is an enuretic boy, A. U. soils because of organic reasons, and S. M. soils because of an emotional reason.

S. T. has an unusual number of fears, M. N. is aggressive and W. B. masturbates.

In all instances the writer has attempted to study the social and environmental factors of the case, the influence which they have upon the child and the clinical treatment.

The Case of C. Z.

C. Z. is a nine-year-old boy of average intelligence who was referred by his stepmother because he was unmanageable and because he daydreamed. His mother was confined to a mental hospital as a hebephrenic schizophrenic shortly after C's birth and her prognosis is stated by the hospital as being extremely poor. The maternal grandparents have told C. that he is responsible for his mother's illness. Although he has not been definitely told that his mother has a mental illness he has seen her several times when the grandparents took her from the institution into their home. At these times the boy was very frightened. He lived with the grandparents for a while and was also placed in an institution.

An unusual marital situation developed. Although the father was not legally divorced, a board of six rabbis allowed the father to remarry so that C. could have a mother. Although the stepmother wishes pregnancy she has not been able to achieve her goal.

Both father and stepmother are naturalized Russian Jews and are very religious. The father is a Hebrew teacher and the stepmother has assisted him upon occasion. C. has to follow a rigid religious routine which he does not completely understand. It is the ambition of the parents that he be a brilliant, highly cultured man and he is constantly nagged to become one.

When he was five years of age C. suffered from rheumatic fever. A resultant heart involvement necessitated rest. Four years later the parents still required him to rest daily in a darkened room. This he disliked intensely. He had little opportunity for play because of his rest period, school and Hebrew School. When he read educational comic books at the clinic he was worried about his stepmother's reaction.

Another unfortunate occurrence was the school transfer which C. experienced. He transferred from a school in another state where there were half-yearly promotions. He entered the second grade where he was a half year ahead of his present class. In this class he was not adequately motivated and was prankish and slightly aggressive toward the other children. There was also a personality clash with the teacher.

> In the course of fifteen months at the clinic the psychiatrist saw the child, and the social worker saw the mother and the school. The situation and child improved. With a double promotion C.'s problems of prankishness and aggression in school cleared up. The home situation was somewhat alleviated when the stepmother was helped to modify some of her attitudes and to lessen the over-rigid religious routine against which the boy rebelled. It was found that daily rest periods were no longer necessary, and the need for the boy to have more time for play with other children was shown.

This is an example of the influence of the social and environmental factors upon the behavior of a child in the latency period. C.'s home situation is very unfortunate for he knows that his own mother is alive and still legally married to his father. He has been told that he is the cause of his mother's illness which has not been described as mental to him. He has seen his mother in a psychotic state and has been afraid of her, however. All of this could cause his daydreaming, for he may wonder about her and her future and may feel guilty about her illness. C. does not accept his stepmother, who rejects him, is overstrict, has guilt about her marital situation, and identifies the boy with his psychotic mother.

He is ahead of his group in school, is not sufficiently motivated, may identify the teacher with his stepmother and daydreams and is prankish as a result.

Another possible cause of his daydreaming is the limitation placed upon his play activities. Daily forced rest and a heavy religious program deprive him of much opportunity

to play with boys his own age--which is so necessary for boys in the latency years.

The Case of J. L.

J. L. is a seven-year-old girl of bright normal intelligence who was referred because of her refusal to attend school. Her father is a graduate of a college of pharmacy and her mother graduated from normal school and taught school for ten years. J. has a brother, age eleven. She feels that her mother, who is described as highstrung, likes her brother better than she likes her, in spite of the fact that her mother spends much time with her. The father, however, is described as being devoted to the patient and he often joins in her play and reads to her. Discipline is handled by the mother, who has upon occasion, whipped the girl. J. was trained for bladder control when she was two years old. The mother stated that she spanked her until she kept dry.

J. is described as one who keeps things to herself and who is not able to talk out what is bothering her. She is further described as strong willed, stubborn, truthful, imaginative, and generous. She has shown no interest in sex and likes to be the center of attention. Her playmates consist of older children as there are few children her age in the immediate neighborhood. She attempts to be a leader in the group.

J. L. attended first grade, where her marks were superior, although she did not especially like school. She attended second grade for two months. After this she was ill with an infected throat. She returned to school for one week and then came home again and refused to attend school--saying that she was afraid of the teacher. She was out of school three weeks because of this. The mother of a classmate told J.'s mother that the children were afraid of their teacher. The friend who told this story is known as a troublemaker and her child told the story to J. Upon investigation it was found that no one else spoke unfavorably of this teacher. No unfortunate incident was known to have occurred at school. It is interesting to note that J. wishes to be a teacher when she grows up. She states that she does not like the children in her class and that she would be willing to attend school if she could be in the fifth grade.

> The psychiatrist saw J. for four months and the social worker worked with the mother and the school. The father was also seen and his efforts were elicited in taking the child to school. The case was closed as improved, the patient modified her attitudes about school, and became more cooperative and easier to handle at home.

This girl may appear to have difficulty in solving her Oedipus conflict as her father is described as being the more kind and interested parent. Her mother, who is a former school teacher is a strict disciplinarian upon occasion. J. may identify the school teacher with her mother and react accordingly. Her desire to be a school teacher when she grows up may be an expression of her desire to identify with her mother. There is sibling rivalry within the family and J. feels that her mother favors her eleven-year-old brother. Her illness satisfied her desire for attention--especially from her mother.

There are additional problems of social adaptation which is shown by the girl's dislike of her class members and her preference for older girls--with whom she played at home.

The home environment possesses many strengths, the economic condition of the family is good, both parents and child are intelligent, and with the clinic's help the situation improved.

The Case of M. H.

M. H. is a nine-year-old boy of superior intellectual ability who is in the class for gifted children. His father, aged forty-seven, was previously married, divorced, and has a twenty-seven-year-old son who is in the army. The father is a truck driver who is described as easy-going, lenient, and a drinker. He has been out of work frequently. The mother, aged thirty-two, is not interested in the father except in regard to his support, and never goes anywhere with him. While in her teens the mother was involved with an older married man, was taken to court for lewdness and spent a year in a women's reformatory. She married Mr. H. shortly after she was released. She is uninterested in sex and says that she hates to have any man touch her. Because of her lack of interest in her husband, Mrs. H. is overinterested in M. She has been overprotective also--keeping him in the house when he would wish to be outdoors playing, and taking him to and from school. She started the school trips after a relative was killed in an automobile accident a year ago.

M. was operated upon for hernia at the age of five, but he has been troubled by this since. His mother says that she keeps him from playing with the neighborhood children as she feels that they are too rough for him and are not his type. She takes him to the movies twice a week.

M. is described as aggressive, imaginative, honest, affectionate, sensitive, and eager for attention. In the class for gifted children his scholarship was described as excellent, but his effort as average. The other children do not like him as he tries to monopolize the recitation period--often shouting answers which are incorrect. The teacher feels he needs much attention and that he sometimes works below the level of the class.

M. was followed by the clinic for three years and improved. The psychiatrist saw the boy for a year and the social worker saw the mother and the school personnel during this time. After a year the boy no longer came to the clinic but the social worker conferred with the teacher of the gifted class periodically for two more years after which time the family moved to another state and the case was closed. After a physical examination it was found that no hernia operation was necessary. One of the goals was the emancipation of M. from his

mother. This was improved by his participation in group activities and more freedom, which was allowed by his mother.

This nine-year-old intelligent boy comes from a home where there has been much economic difficulty. The adjustment to a class where most of the children had no serious economic problems was undoubtedly difficult for him. This may have influenced his aggressive behavior in school.

The emotional problem of the home was the mother's rejection of her husband and of anything concerned with sex and her overdevotion to and overprotection of her only child. The resolution of M.'s Oedipus conflict may have been difficult as his mother did not help with this, and his father appeared to be a weak person who drank often and may not have been a person with whom M. could easily identify.

When M. was in the school situation he may have identified the teacher with his mother and wished the overattention in school which he received at home, and acted in an aggressive manner to obtain this.

The Case of G. R.

G. R. is an eight-year-old boy of dull normal intelligence who was referred to the clinic because of a reading difficulty, but who was also enuretic. His mother is twenty-seven and his father thirty-five. Although his father owns a small business his income is marginal. G. has a year-old brother who is favored by his mother and whom G. does not like. At six years of age G. had his tonsils and adenoids removed. He is

a poor eater and craves milk, does not sleep soundly, rubs his chin vertically from his mouth downward. Several years ago he was observed masturbating and was beaten until he stopped. He wets the bed continually and has never been fully trained. He has not been given sex instruction, has asked no questions, and thinks boys and girls are alike.

He is described as being bossy, suspicious--not trusting anyone except his father. He does not have many playmates and his father makes a companion of him--interesting him in electricity.

G. hates school, where he is in the third grade. He dislikes both his teacher and his subjects. His work is poor, he does the least possible amount and wants individual attention. He has a pronounced reading difficulty. He rationalizes this by saying that he he won't need to read if he becomes a telephone lineman, which is his ambition.

G.'s mother seems to be overwhelmed by the situation. She is an easygoing person who has spanked him, but does not want the father to punish him. She feels that she may have "brought him up by the book too much". G. feels that his mother is stupid. G. feels that his father is smart, however, and respects him. His father has punished him by using a leather strap with a hook on it.

After twenty-one months this case was closed as improved. Treatment consisted of psychotherapy given by the psychiatrist to the child and reading assistance by the reading tutor. The social worker worked with the mother and did some supplementary case work with the father as well as with the school. The boy was demoted to the second grade and his school work improved after this. G.'s enuresis improved.

In the G. R. case there are many factors to consider. Although the immediate problem was the reading disability and poor school adjustment, the rejection by his mother appears to be of prime importance. The removal of his tonsils and adenoids at the age of six--the time when the Oedipus conflict is usually resolved, might have caused

considerable fear of castration. The birth of his brother when he was seven did not help him as the brother was favored by his mother. The harsh discipline enforced when he was observed masturbating several years previously may have resulted in his staying enuretic instead of becoming dry--for it was less dangerous to wet the bed than to masturbate.

He does desire attention, love, and physical gratification, and he may have hostility and revenge against his mother who does not give this desired gratification. He may also have some unconscious feelings of hate for his father, who has been a harsh disciplinarian and yet he may feel guilt about this for his father has been very good to him also. These feelings may find expression in the enuresis.

One need consider the possibility of his identifying the teacher with his mother and also the effect which his emotions have upon his reading ability.

The Case of A. U.

> A. U. is a nine-year-old boy of dull normal intelligence who was referred by the school nurse because of truancy, soiling, and wetting. He comes from a home of poor economic status. His father is a foreman in a tack factory, and A. is the sixth of eight children. The relationship between his parents is poor. They have not spoken to each other for seven months--since the birth of the last child. Some children take the father's side; others agree with the mother. A. never experiences discipline. Mrs. U. is unkempt and dirty and Mr. U. is abusive. Ten years before another agency reported that the father had a spell of insanity at which time he destroyed some of the furniture and was arrested. The mother has difficulty with her hands, which she said, have been crippled since childhood and prevents her from doing some of the housework.

> A. is described as a cheerful, lovable, helpful child who is not particularly disobedient or rude. When he was five years old he was injured when he fell off a swing on to a stick which he was using to propel himself. The stick penetrated his rectum. After this his soiling started. Doctors have said that he has no control over his rectal muscles and a specialist advised that an operation might help, but it was very hazardous and might not be successful.
>
> A. is in the third grade at school and has repeated the second grade. He is well liked by his classmates and does not appear to be left out of general play. He is prone to soil while at play, however, and the children tease him about this and call him "Barny". He likes his teacher and wishes to do favors for her. Although he truanted five different times during the past month he could give no reasons for this.
>
> The psychiatrist felt that there was a question of an organic basis for the soiling which was in turn a possible basis for truanting. The social worker felt that the truanting might be based on environmental factors.
>
> The case was known to the clinic for eight months after which time the truanting and enuresis were overcome. The psychiatrist worked with the child and the social worker with the parents and school. The goals were to relieve some of the tensions and to bolster up some of the insecurity.

This nine-year-old boy comes from a very poor home--both in regard to financial status and emotional security. There appears to be an organic basis for his soiling, but not for his enuresis. The soiling causes his class- and play-mates to tease him about his odor and the result is that he truants from school although he says that he likes school.

One of his problems may be the type of father which he possesses, with whom it would be hard for him to identify.

Another type of soiling problem can be seen in the following case illustration in which there is no organic

basis. Here we can see the influence of the social and environmental factors on the child's soiling.

The Case of S. M.

S. M. is a seven-year-old boy of average intelligence who was referred by a hospital because of his soiling. His father, who is thirty-five, has received eight years of schooling and is employed as a mechanic. His mother, who is thirty-one, has completed eleven years of school. The economic status of the family is poor--which has necessitated the mother's working outside the home occasionally. At these times S. was left with the maternal grandmother, whom he did not like. S. has a twelve-year-old sister who feels that S. is the favored child. The parents do not agree on the discipline, which formerly consisted of spanking.

S. experienced a traumatic incident at the age of three when he nearly drowned. Now S. has a fear of water and a fear of the dark.

His personality is described as cheerful, but with occasional flareups of temper. He is generous, affectionate, honest, and truthful.

At school he is in the second grade. When he entered school a year ago his soiling started. Prior to this, at the age of five, he had started the first grade, attended for three months, did not like it, and was taken out of school.

S.'s soiling usually occurs on the way home from school or when he is running or playing. He is unpopular with the other children, is a bully, but is also babyish and cries easily. He insists that his mother be at home when he is around and he wishes to know exactly where she is at all times.

Upon investigation it was found that the mother treated the child with suppositories when he was a baby and from the age of two and a half until the present time she has given him enemas twice a week. He suffers from diarrhea every summer.

The psychiatrist felt that the probable influential factors were the mother's nervous temperament which reflected itself upon the boy, and the mother's fixation at the anal level.

> The mother's working outside the home contributed to S.'s insecurity and extreme dependency upon the mother. In turn the mother may have had guilt feelings and compensated by extreme overprotection.
>
> The psychiatrist saw the boy and mother for thirteen months after which time the case was referred back to the hospital for a re-examination for possible organic causes. After a camp placement had been arranged and the boy was able to get away from his mother, it was reported that his condition had improved and that clinic service was no longer needed.

This boy had a traumatic experience when he nearly drowned. The most serious problem appears to be his mother's interest in his excreta as the psychiatrist suggests. He does not want to leave his mother even for school. The mother's working outside the home has not helped his security, nor did his unhappy entrance into school at the age of five. Unfortunately there was some resistance on the part of the father to the boy's attendance at clinic. It is interesting to note that when he has a happy experience away from home at camp when he is a few months older his soiling stopped.

The Case of S. T.

> S. T. is a ten-year-old boy who was referred from a hospital because of his sleeping difficulties.
>
> His father is a constable, who completed ten years in school. His mother was born in Russia, coming to this country as a young girl and completing eight years of school. Mrs. T. is more ambitious than her husband and considers herself superior to him. S. has one brother, aged four. Both parents prefer the younger brother. The mother appears to be ambivalent toward the patient telling of times when she dislikes him. She has often told both children that they make her so ill that she will die. The patient has a fear of death.
>
> Two years ago there were several deaths in the

neighborhood. A year ago the maternal grandmother and uncle died. When the patient questioned his mother, she told him that people don't really die, but go to sleep and live in Heaven. She told him that this happened to everyone. Now S. is afraid that he will die in his sleep. He is also afraid of the dark and has his mother sit in a room adjoining his bedroom while he is going to sleep. He has said that he would like to have his mother sleep with him. He is afraid to go to the bathroom alone at night. He also has a pain in his body nearly every night when he goes to bed. Whenever he hears of someone's illness, he feels that he has the same illness.

When he was four years of age he was afraid to sleep alone and at that time his mother would lie down beside him when he was going to sleep.

S. has had several traumatic experiences. He had his tonsils removed when he was two and again at six. When he was four and one-half years old he had difficulty with his teeth. He did not know he was going to have them pulled until he woke up one morning and found the dentist in his home. He has had nightmares almost every night since then. At nine years of age he had abscessed teeth and swollen glands which required hospitalization. His mother is now concerned because she thinks that his penis is not growing.

Both parents have a fear of death. In spite of this the parents disciplined the patient because of his sleeping difficulties. Both have beaten him until he was black and blue and have tried to tease and shame him out of this behavior. At one time they took him to the state hospital as a threat.

A year ago S. was involved in sex play with a girl. When he told his mother of this, she told him the facts of life. His mother felt that he was less concerned about this than whether his mother would tell his father about his experience. The mother did not tell the father, but now holds this over S. as a threat.

He is described as a truthful child who is sometimes defiant toward his mother. He has one particular boy with whom he plays and he also delights in playing house with the girl downstairs.

His adaptation to school has been poor. He is of average intelligence and is in the fourth grade, but does not want to go to school. He sometimes refuses to attend. When he does attend school he sometimes puts

> his head on the desk and moans. He refuses to attend hygiene class as he can't stand mention of the inner organs of the body. The teacher has scolded S., but to no avail.
>
> The Thematic Apperception Test given by the clinic psychologist showed an unresolved Oedipus situation and practically no expression of love for his father. It also showed a fear of punishment and of bodily mutilation. A bodily injury appeared as means of getting love and protection. Death seemed linked in his mind with sex.
>
> For treatment the boy saw the psychiatrist and the mother saw the social worker. It was felt that both the mother and the boy needed intensive treatment. Unfortunately the family lived some distance from the clinic and the mother was resistant at times. During the five years the case was known to the clinic it was opened and closed three times. When it was finally closed there was some improvement noted--especially in the boy's social adjustment.

In this example we can see a very poor home situation where both parents have fears themselves and where their management of S. has been sadistic and thoughtless. There is sibling rivalry, with both parents favoring the younger brother. The death of relatives and the unexpected appearance of a dentist when the boy needed extractions all contributed to his fear of death--which comes when one is asleep. His mother's threat to die contributes further to this fear. It appears as if his Oedipus conflict were unresolved as his father is a brutal man with whom it is difficult for S. to identify. His mother further contributes to this by showing interest in the size of his penis, by staying near him when he goes to sleep, and by telling the children that they make her so ill she will die. S. has guilt about his sex experience with a young girl and according to the personality test links

death with sex. His desire to possess his mother may be the instinctual desire which he is unable to gratify. There may also be a fear of castration present which his operations may increase.

All of his fears result in his poor social adaptability which is culminated in his refusal to attend school.

The Case of M. N.

> M.N. is a seven-year-old boy who was referred by a hospital because he is a behavior problem. He had originally attended the hospital clinic because of dizzy spells but no organic basis was found. His parents are young and are of different religious faiths. There is much friction in the home over religion. The mother is of one religion and married outside her church. The father is of another faith. M. is the oldest of four children. His three sisters have been brought up in the mother's religion and he has been brought up in the father's religion.
>
> The discipline in the home is inconsistent. The mother claims that she cannot manage M. and the father disciplines him spasmodically. Each parent blames the other for the boy's behavior.
>
> The parents lived with the maternal grandmother, who spoiled M. When M. was one and a half the maternal grandmother died. At this time there was a new baby which took most of the mother's time.
>
> Traumatic illnesses included a fracture of the foreleg at four years and the removal of his tonsils and adenoids at six years.
>
> M. is described as a light sleeper who suffers from night terrors. He sucks his thumb, especially at night after he has been punished or when he has had a temper tantrum. He occasionally bites his nails.
>
> He is afraid of being hurt physically--fearing such things as injections. He is also described as being afraid of his mother, other boys, and the school principal. It was felt that the mother is a tense and punishing person.

M. has been destructive in his behavior--throwing rocks, breaking windows, etc. He has truanted from home, told lies, and broken the cat's leg.

The psychiatrist described him as a negative personality who is said to be surly, stubborn, disobedient, disruptive, impudent, and saucy. His mother also stated that he calls her abusive names and often fights with the other children.

M. does not get along well with his playmates either. He fights often, occasionally plays with a group of tough boys, but on the whole has just one friend, a mentally retarded boy.

M. is in the second grade at school and has made a poor adjustment. He likes his teacher very much and writes her notes saying that he loves her. The teacher thinks that he is loveable, but she also speaks of his arrogance.

The psychiatrist later described him as "an emotionally disturbed child reacting to his mother's rejection with hostility and aggression. Thumbsucking, nailbiting, terrors, and fears show this."

The case was known to the clinic for twenty-eight months during which time the psychiatrist saw the child and the social worker saw the mother and the school. It was felt that he improved somewhat under modified discipline, but continued deeply maladjusted and developed an asthmatic condition. After this the mother was pregnant and unable to attend the clinic and the hospital continued the supervision of the boy. The hospital reported improvement of the asthmatic condition after a camp placement.

In this case the close relationship between frustration, anxiety, and aggression can be seen. M. is rejected by his mother and has been ever since the maternal grandmother died. He has certain fears, of bodily injury, of his mother, of other boys and the school principal. He reacts to his rejection by acting in an extremely aggressive manner, fighting often, being cruel, destructive, lying, and truanting.

The inconsistent discipline and the religious

disagreement are environmental factors which also need consideration and which in turn affect the child for he feels insecure when he does not know whether or not he will be punished. He also feels different from his sisters because they have one religious faith and he has another.

The Case of W. B.

W. B. is a six-year-old boy of high average intelligence who was an only child until ten months ago when a three-year-old foster child was taken into the home. This child is scheduled to leave shortly. W. was referred to the clinic by his mother because of his masturbation.

His father, aged thirty-six, had ten years of schooling and is employed as a sheet metal worker. His mother has been at home and is thirty-four years old. The mother has a poor relationship with the maternal great-grandmother who lives on the other side of the house. When the mother was younger, the maternal great-grandmother would threaten to kill herself and to send Mrs. B. to reform school. The psychiatrist felt that Mrs. B. has fears of being psychotic.

The relationship between W. and his parents appears overtly to be a good one although his mother is inconsistent in her discipline. W. has received very little physical punishment for discipline.

W. has masturbated since he was eighteen months old. He stays in the bathroom an especially long time, rubs his legs together, and rubs himself against chairs. He told the psychiatrist that a year ago a twelve-year-old boy tied him to a tree and masturbated him. This occurred several times, but has finally ceased. W.'s mother is much concerned about W.'s masturbation and the maternal great-grandmother has said that he will become psychotic.

He also became involved in sex play with a girl neighbor, supposedly at her suggestion. Still later showed a sadistic tendency and was cruel toward a cat--burning him and trying to pull him apart. He also killed a pet rabbit. This was since the foster child was in the home.

W.'s disposition was otherwise described as happy and affectionate--especially toward his mother. He daydreams

at times and is dependent in many ways.

At school he is in the first grade, which he likes very much. The teacher feels that he is slow and does not apply himself. She has noticed him rubbing himself. She feels that he is in need of attention and achieves this in school by cutting up and acting silly.

The psychiatrist saw both the mother and the boy for a period of twenty-three months. The social worker visited the home and school. The case was closed as improved after this time, for the boy stopped masturbating and his sadistic tendencies subsided.

Masturbation is a common occurrence between the ages of three and six. W. has not had opportunity to give up this pleasure as his mother took a foster child into the home as he entered his latency years. He also was masturbated by an older boy. The necessity of sharing his mother's love with another child may result in his continuation of his self-gratification, the masturbation as well as his attention-getting behavior at school. The cruel impulses which W. indulged may also have given him pleasure. The sex play with the girl neighbor was thought to be at her suggestion. This undoubtedly resulted from sexual curiosity on his part too.

CHAPTER VI

TREATMENT

The usual procedure in the Brockton Child Guidance Clinic is for the psychiatrist to work directly with the child and the social worker to work with the mother. Occasionally the psychiatrist works with the mother too, but this is the exception rather than the rule. The social worker also works with the school and with any other resources used. If reading and speech help is deemed necessary the reading and speech tutors also work with the child. When the psychiatrist sees the child she determines what the goals are to be. In doing this she recognizes the irremedial factors which may include the economic, psychological, intellectual, etc. The goals may be limited, aiming for a partial adjustment of the child to his environment, or they may be unlimited and aim for a complete adjustment and insight in the child.

The psychiatrist uses play therapy with the children and through this helps them to release hostility, to ventilate conflicts and to relieve tension.

The social worker sees the parent and the school. With the parent casework may be intensive or supportive. In intensive casework the social worker sees the mother weekly or biweekly and her goal is to help the mother understand the child's problem. Modification of parental attitudes is an important part of the social workers treatment. In supportive casework the social worker tries to help the mother by giving

her acceptance and reassurance, but she does not anticipate much change in the mother's insight into her problems.

When the social worker visits the schools she interprets the results of the psychological tests to the teachers. She also explains her role in the treatment picture and discusses with the teacher ways in which the child may be helped. The social worker also keeps informed of the marks which the child attains, and his strengths and weaknesses in the school situation.

TABLE XII

OUTCOME OF THE THIRTY CASES UPON CLOSING

Outcome	Frequency
Much improved	2
Improved	22
Unimproved	2
Transferred	4
Total	30

It can be seen that improvement was noted in twenty-four of the thirty cases upon closing. The four cases which were transferred were referred to another agency. A case is closed as "improved" when some factor in the situation is strengthened so that a child's problem or situation is helped in some way.

A case is closed as "much improved" when all weaknesses have been strengthened and the whole personality appears to have improved. A case is closed as slightly improved when only the problem referred and not the entire situation has

improved. A case is closed as "unimproved" when the situation remains the same as it was when the problem was referred.

TABLE XIII

NUMBER OF MONTHS CASE KNOWN TO CLINIC

Number of Months	Frequency
1-9	9
10-19	10
20-29	6
30-39	1
40-49	1
50-59	0
60-69	0
70-79	3
Total	30

The gifted children are usually followed for a longer period of time. Besides the special interest in an unusual class of this type there is the interest of seeing how they adjust to the regular classroom procedure again when they go to junior high school. The three children known from seventy to seventy-nine months were gifted children, as were one at forty months and one at thirty months. The other gifted child left the city after being known to the clinic from ten to nineteen months.

Excluding the gifted group it appears that eighteen out of twenty-four of the children were known to the clinic less than twenty months. Excluding the gifted group the average length of treatment was seventeen months. The average length of treatment for the gifted group was fifty-one months, and the average length of treatment of the group as a whole was

twenty-four months.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The writer has attempted to study the social and environmental factors of children in the latency period who were referred to the Brockton Child Guidance Clinic. Thirty closed cases were chosen because they had social histories and because the children were in the age group from six through twelve, the so-called latency years. There were twenty-six boys and four girls in the group studied.

It was found that many types of problems were presented by these children which were typical of what is to be expected during the latency period. The group of thirty cases contained six children who were referred as candidates for the class for gifted children, but who also presented problems. Two of the children were found to have an organic problem as well as an emotional problem and were transferred to a hospital for further study.

The largest group of referrals, nineteen of the thirty cases, came from the school, thirteen of these because of poor school adjustment. This might be explained by the fact that adaptation to school can be a difficult transition for the child in the latency years, by the fact that there is an educational consultant who is alert to these problems in the Brockton school system, and by the fact that there is close cooperation between the school system and the clinic.

It was found that most of the children had intelligence

quotients which fell in the average range, while there were a few who were higher and few who were lower. It was found that there was one child who was classified as having borderline intelligence, eight as having dull normal intelligence, eleven who were average, three as bright normal, and seven as very superior. Six of the seven very superior children were candidates for the gifted class. It was felt that some of the eight children classified as dull normal were actually of average intelligence as the influence of emotional factors upon the intelligence quotient scores should be considered. The first four grades included the largest group represented in the study and five of the fourth grade children were referred as candidates for the gifted class who presented emotional problems. The writer felt that awareness of the teachers and the educational consultant of the clinic function was an influential factor here.

The influence of the home was noted, and it was felt that many of the children referred had difficulties in resolving their Oedipus conflicts, which is not too unusual an occurrence in the latency period. Those children had difficulty in solving their Oedipus conflicts for several reasons. In some instances the parent of the same sex was a weak, cruel, or an alcoholic person with whom it was difficult for a child to identify. In the case of a few of the boys an overprotective, overdevoted mother made it difficult for a boy to cease being in love with her.

The influence of the family upon the school has been seen in the type of identification the child has been able to make with the teacher or others in authority. This also has been reflected in the attitudes of the child. This is usually noted in the latency period.

In considering the direct environmental factors of the home, it was found that twenty-six of the thirty children came from a normal (two parent) home. This is different from what one would expect as the emphasis in the past has been upon broken homes and the effects which they can have upon a child. This might lead one to believe that the absence of both parents in the home is a panacea. The writer found affirmation of the need to consider the parental attitudes within the home. In a child guidance clinic such as Brockton one has the opportunity to observe the need for modification of parental attitudes which exert such a profound influence upon the child. Many of the children studied by the writer experienced parental rejection. Others experienced parental overprotection which, in extreme cases, resulted in their dislike of leaving home to attend school and also affected their social adjustment when they did leave home.

No mother worked outside the home consistently, and the largest number of fathers were employed as skilled or semi-skilled laborers. The largest number of families contained two children--twelve out of thirty families contained this number of children.

Some of the problems presented in this study for the most part are unlike what one would expect for children in the latency period, whereas other characteristics of the children are typical of the latency years.

Eleven of the children or 37 per cent presented difficulties in bladder control. One of these was found to have an organic basis. Ten were felt to be of psychological origin. Although enuresis does occur during latency it is not a typical problem of the period. English and Pearson suggest that causes of this may be the desire for attention, for love, and physical gratification, for hostility and revenge against the parent who doesn't give the desired gratification or against the other parent who may prevent this, the memory of the danger by which the revenge is gratified and the need for punishment for such desires.[1] The parental influence can be readily seen in such cases.

Soiling is not a typical latency problem, but may occur. The causation may be the same as enuresis. One of the four children who soiled had an organic injury.

There were twelve children who had undue fears, eight of whom were especially afraid of bodily injury, mutilation or death. When one studied the backgrounds of these children one saw many traumatic experiences had occurred. In some cases a child had experienced several deaths among relatives and friends. In other cases the child had sexual experiences

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[1] O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults, p. 128.

either with other children or of a masturbatory nature. Some of the punishment meted out to these children had been harsh with the result that the instinctual desires remained, but the children were unable to gratify them. In still other cases the Oedipus conflict was not completely resolved and the child still had the desire to possess the parent of the opposite sex and to hurt the parent of the same sex. The result of this was guilt and anxiety.

Twelve of the children experienced sleep disturbances. Two of them walked in their sleep, three talked in their sleep, two had insomnia, and five had night terrors. The influence of anxiety upon this was noted.

Disorders of the oral function included twelve children who had food fads and would not eat certain foods. In no instance was this a serious problem. Dislike of certain foods is common during the latency years as well as during other periods of a child's life. Three of the children studied sucked their thumbs. Upon investigation it was found that these children experienced parental rejection which caused them to cling to this method of gratification. This is not a typical characteristic of latency.

Five of the children bit their nails, which is not usual behavior for the latent child. In all cases the child's relationship with his mother did not appear to be a warm one. The findings appeared to substantiate English and Pearson's

suggestion of the child's desire to annoy and humiliate the parents. One can also see instances where the child has the desire to punish himself for his resentment.[2]

Aggressive behavior is to be expected during the latency period. The children exhibit this not only in their fights, but also in some of their sports. Many, but not all, of the children in the group were found to be aggressive. Seventeen of these children showed their aggression in such a forceful manner that it was considered a clinical problem. The most common symptom of aggression was excessive hitting and fighting, which nine children exhibited. Five of the seventeen aggressive children exhibited this symptom only, whereas twelve of the children showed their aggression in more than one way, including truancy, cruelty, stealing and destruction of property. English and Pearson in discussing some aggression suggest that one cause may be the resentment which the child has because he has not received especially considerate or kind treatment from adults in his past.[3] The worker found that one cause of the behavior of the excessively aggressive child was a lack of love often evidenced by a parent's rejection.

In observing the play activities of the children in the group it would found that most of the children played in gangs,

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[2] O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, p. 196.

[3] Ibid., pp. 137-138.

usually of the same sex and showed little interest in the opposite sex, which is typical of the latency period. Seven boys were known to have engaged in sex play--four of these with other boys and three with boys and girls. Seven of the children masturbated. This would coincide with the general theories that much interest in sex is not typical of the latency period. Possible causes of the sex play may be the curiosity which a child exhibits in regard to the difference between the sexes. Sex play as well as masturbation may also be due to a lack of love.

Treatment consisted of the psychiatrist working with the child and the social worker with the mother in most cases. In one instance speech tutoring and in two instances reading help was also employed. Twenty-four of the cases were closed as improved, the greatest number in a period less than twenty months. For the group as a whole the average length of treatment was twenty-four months. Excluding the gifted group the average length of treatment was seventeen months. The average length of treatment for the gifted group was fifty-one months.

Approved,

Richard K. Conant

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Dean

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APPENDIX

SCHEDULE

Case Number_____ Date of Intake_____
Case Name _____ Date Closed _____
Age _____ Sex _____ Source of Referral_____
Problem as referred:_____ Additional Problems____

Health_____

Family Background
Number of parents in home _____ Relationship between them

Age of father _____ Age of mother _____
Education of father _____ Education of mother _____

Occupation of father _____ Occupation of mother _____
Immediate foreign background _____
Evidence of ambivalence
Type of discipline

Siblings:
Age _____ Sex _____
Close Attachments
Rivalry

Traumatic Experiences
Death of parent or sibling
Birth of sibling
Placement
Hospitalization Operation
Physical handicap
Affectional difficulties
Sex experiences

Habits
Eating
Sleeping
Masturbation
Enuresis
Soiling
Thumbsucking
Nailbiting

Personality Traits
Fears and anxieties
Aggression
outward
inward
Mood reactions
cheerful
depressed
Temper outbursts
Imagination
Attitude toward cleanliness and order
Initiative
Interest in sex
Awareness of problem

Social Adaptability
Attitude toward authority
Outgoing Withdrawn
Type of play
Type and number of playmates
Role in group
Acceptance by playmates

School
I.Q._____ Grade_____

Grades failed_____
Adjustment to school situation_____
Attitude toward teacher_____
Teacher's attitude toward child_____

Treatment
Length_____

Outcome_____

Work of psychiatrist_____

Work of social worker_____

Additional work _____

Interpretation of case _____